SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

PDD Waiver Freedom of Choice

Individual's Name: _____
Address: _____

_____

Phone #: _____

(Please type or print)

This is to certify that the above named individual was informed of the feasible alternatives under the waiver, given the opportunity to choose between institutional and home and community-based services and was informed of the right to request a fair hearing. The individual has selected by written acknowledgment, or by the written acknowledgment of his or her representative, to receive the option marked below.

Signature: _____ Date: _____

Service Coordinator/Early Interventionist

Service Coordinator/Early Interventionist's Name: _____
Address: _____
Phone #: _____

(Please type or print)

I, or my authorized representative, have been afforded an opportunity to make an informed choice of receiving either institutional or home and community-based services. My and/or my representative's signature below indicates that at this time, I have chosen to receive:

☐ **Home and Community-Based Services (PDD waiver)**
☐ **Institutional Services (ICF/MR)**

In the event that I have not been informed of feasible options under the waiver or been given the option of institutional or waiver services, I understand that I have the right to request a fair hearing.

Recipient's Signature: _____
Date: _____

Representative's Signature: _____
Date: _____

Representative's Name: _____

Representative's Address and Phone #, if different from Recipient's: _____

_____